

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

30261

1. PLACE OF DEATH
 County Scott Registration District No. 820
 Township Selwanna Primary Registration District No. 4496
 City Oran (No. _____) St. _____ Ward _____

2. FULL NAME James Wm Swain
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF Alice Swain

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9/26/54

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>76</u>	<u>11</u>	<u>-</u>	<u>-</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farming
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/25 1931

17. I HEREBY CERTIFY, That I attended deceased from 8/17, 1931, to 8/20, 1931, that I last saw him (alive on 8/12, 1931, and that death occurred, on the date stated above, at 9 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Suppurative Pyelitis (?)
(Diagnosis not positive)
1931 (duration) - yrs. 6 mos. - ds.

9. BIRTHPLACE (CITY OR TOWN) Ky
 (STATE OR COUNTRY)

10. NAME OF FATHER Don't

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ky.
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Don't know
 (STATE OR COUNTRY)

CONTRIBUTORY (SECONDARY) 1931 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH: _____

14. INFORMANT Pats Swain
 (Address) Oran Mo

15. FILED 9/10, 1931 P. Pickman
 REGISTRAR

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) J. A. Chase, M. D., 19 _____ (Address) Oran Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Oran Mo DATE OF BURIAL 8/27 1931

20. UNDERTAKER J. A. Chase ADDRESS _____

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

OCT 29 1931

